DENTAL MANUAL

Kentucky Medicaid Program
Dental Benefits
Policies and Procedures

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

KENTUCKY MEDICAID PROGRAM

DENTAL MANUAL

POLICIES AND PROCEDURES

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SECTION I - INTRODUCTION

I. A. INTRODUCTION

The Kentucky Medicaid Program Dental Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual provides basic information concerning coverage, policy, and reimbursement. Precise adherence to policy shall be imperative.

This manual shall provide basic information concerning coverage and policy. It shall assist providers in understanding what procedures are reimbursable.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both federal and state statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program serves eligible recipients of all ages. Kentucky Medicaid coverage and limitations of covered health care services specific to the Dental Program shall be specified in the body of this manual in Section IV.

KENTUCKY MEDICAID PROGRAM

SECTION II

SECTION II - KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the. Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients.

If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. The Medicaid Program shall be the payor of last resort. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable payment.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice within their scope of licensure accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each eligible medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program in accordance with 907 KAR 1:672.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same

service shall not be tendered to the recipient, and payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

Providers of medical services or authorized representatives shall attest, by their signatures, that the presented claims shall be valid and in good faith. Fraudulent claims shall be punishable by fine or imprisonment, or both. Facsimiles, stamped or computer generated signatures shall not be acceptable.

The provider's adherence to the application of policies in this manual shall be monitored through either postpayment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the postpayment review of claims shall result in a refund request.

If a refund request occurs subsequent to a postpayment review by the Department for Medicaid Services or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to:

DIVISION OF PROGRAM AND PROVIDER SERVICES
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH SERVICES
275 EAST MAIN STREET
FRANKFORT KY 40621

If no response (refund or appeal) has been filed with Medicaid by the provider within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from future payments.

C. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define "Timely submission of claims" as received by

Medicaid "no later than 12 months from the date of service." Received is defined in 42 CFR 447.45 (d) (5) as follows, "The date of receipt shall be the date the agency received the claim as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. Claims shall not be considered for payment if more than twelve (12) months have elapsed between EACH RECEIPT of the aged claim by the Program.

D. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, providers and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card, the name of the case manager and pharmacy shall appear on the face of the card.

E. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary care provider. The primary care provider shall

be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

F. Kentucky Health Care Partnership Program

In accordance with 907 KAR 1:705, the Department shall implement, within the Medicaid Program capitation managed care system for physical health care services. The program places an emphasis on access and continuity of care, quality assurance and improvement in health outcomes for participating Medicaid recipients. The Kentucky Health care Partnership Program shall be implemented incrementally statewide, beginning in 1997. Partnerships should be operational by January 1, 1999, or the state will begin a competitive bid process. Medicaid recipients residing in partnership regions and who are not recipients of Medicaid long term care services shall be eligible to receive Medicaid services through regional Partnerships. If a health care provider chooses to provide Medicaid services through the Kentucky Care Partnership Program, the provider shall enroll in a regional Partnership as a Medicaid network provider. The provider must agree to provide, or arrange for the provision of, all Medicaid covered services in accordance with the terms and conditions specified by the Department. The provider must also agree to the terms, conditions, and administrative procedures specified by the partnership related to the delivery of services. Health care providers may contact the Department for Medicaid Services for additional information relating to Medicaid services under the Kentucky Health Care Partnership Program.

G. Kentucky ACCESS

In accordance with 907 KAR 1:7 10, the Department shall implement, within the Medicaid Program, a capitation managed behavioral health care system called Kentucky ACCESS. Kentucky ACCESS shall be implemented on a regional basis, much like the physical health partnership regions. Services covered under Kentucky ACCESS will generally include those services provided by psychiatrists, community mental health centers, psychiatric hospital units and psychiatric residential treatment

facilities (PRTF), except for children in the EPSDT program. It also includes other medically necessary services such as services for alcohol and substance abuse.

H. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Under the EPSDT program, Medicaid eligible children, from birth through the end of the child's birth month of his twenty-first (21) year, may receive preventative, diagnostic and treatment services by participating providers. The goal of the program is to provide quality preventative health care by performing prescribed screenings at specified time intervals according to age (termed a periodicity schedule) to identify potential physical and mental health problems. These screenings shall include a history and physical examination, developmental assessment, laboratory tests, immunizations, health education and other tests or procedures medically necessary to determine potential problems. Another goal of the program is to reimburse for medically necessary services and treatments, even if the service or treatment is not normally covered by Kentucky Medicaid. However, the service or treatment must be listed in 42 USC Section 1396 d(a) which defines what services can be covered by state Medicaid programs. More information regarding the EPSDT program can be obtained by calling the EPSDT program within the Department for Medicaid Services.

I. EMPOWER Kentucky Transportation Initiative

In accordance with 907 KAR 3:065, the Department shall implement, within the Medicaid Program, as an EMPOWER Kentucky initiative, a capitation non-emergency medical transportation delivery system. The Department has entered into a contract with three other Cabinets to implement this program incrementally statewide beginning in June 1998. This new system is designed to extend service to areas of the state currently under-served, provide transportation alternatives to more people, encourage efficiency and discourage fraud and abuse.

CONDITIONS OF PARTICIPATION

SECTION III

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. General Information

For purposes of participation in the Kentucky Medicaid Program, a Medicaid provider number shall be assigned to each provider. Dental provider numbers have a prefix of "60," and clinic provider numbers have a prefix of "6 1." Dental procedures performed by the "60" individual dental provider of a designated "61" dental clinic shall be submitted by the participating provider that performed the billed service. Failure to report the correct provider number on the claim shall result in nonpayment or incorrect payment of claims. If a provider is terminated or suspended from Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date shall not be payable.

Services provided shall be billed on claim forms accepted by the Medicaid Program.

B. Freedom of Choice Concept

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the program for the medical care provided. The signing of the application for participation shall not, in any way, infringe upon the individual freedom of any provider.

C. Individual Provider

All dentists licensed to practice dentistry in the Commonwealth of Kentucky (or in the state in which they practice) may, upon approval of the Department, participate in the Kentucky Medicaid Program by completing participation agreements and requesting payment for covered medical services provided to eligible Program recipients. In order to bill1 the Program and receive reimbursement, the dentist shall have a current,

valid license to practice dentistry at the time medical services or procedures are performed.

In addition to a state dental license, all oral surgeons, orthodontists and prosthodontists shall provide proof of specialty by their appropriate state licensing agency or proof of board certification when state specialty licensure is not required.

By submitting a signed dental claim form the provider certifies that the foregoing information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the Kentucky Medicaid Program. The provider understands that payment and satisfaction of this claim will be from federal and state' funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.

All dental benefits of the Program shall be considered to be "Service Benefits." This means that additional payments for the service shall not be accepted from the recipient without full forfeiture of right to payment by the Program. The dentist may request and accept payment of any deductible and coinsurance amounts due for the same dental service covered by both Medicare (Title XVIII) and Medicaid (Title XIX). If payment for a covered service is due and payable from a third party source such as an insurance plan, or some other third party with a legal obligation to pay, the amount payable by the Department shall be reduced by the amount of the third party obligation, subject to the Program maximums.

Dentists may choose those procedures for which they wish to bill the Program. Other financial arrangements may be made with the recipient for those procedures the dentist chooses not to bill to the Program. Only the procedures listed in the Dental Manual shall be payable by the Program. It shall be the responsibility of the recipient to make appropriate financial arrangements with the dentist for services not payable by the Program.

D. Dental and Physician Clinic and Professional Service Corporations (P.S.C.)

Salaried dentists who are employed by a clinic or professional service corporation may request that payment for services they provide to Kentucky Medicaid recipients be made directly to the clinic or professional service corporation., This system of payment shall be accomplished if the clinic or professional service corporation meets the following definition.

1. Definitions

(a) Clinic: Under the Kentucky Medicaid Program, a clinic shall be defined as a group practice in which several physicians and dentists work cooperatively, primarily to provide outpatient service..

(b) Professional Service Corporation: In the same manner as shall be defined in Commonwealth of Kentucky Revised Statutes, Chapter 274 (KRS 274.005 through KRS 274.990), or in states other than Kentucky, as may be defined by the appropriate State Law.

2. Staff Requirements

(a) The clinic shall have a designated director who is currently licensed to practice medicine in the state where services are provided.

(b) The clinic shall have a designated clinic administrator to supervise and coordinate all administrative functions within the clinic.

(c) The clinic shall have an adequate number of medical assistants on staff.

(d) The clinic shall employ an adequate number of clerical personnel.

3. Documentation Required for Dental Providers in a Teaching Hospital

Residents, interns and students may provide services to program recipients in a program participating, "teaching hospital." Residents, interns, and students shall not, however, bill Medicaid for their services. A teaching hospital dental provider who is not a resident or intern shall be considered the primary attending physician and may bill Medicaid for services performed by the residents, interns, and students for which the provider is responsible. This dental provider may bill Medicaid if one (1) or more of the following services has been provided:

(a) A review of the recipient history, examinations, and tests, and the conduction of interviews regarding patient progress;
(b) A personal examination of the recipient; and
(c) A confirmed or revised diagnosis of the recipient's condition.

The performance of activities listed above shall be documented in notes or orders contained in the recipient's medical records. These notes or orders shall be acknowledged, signed, and dated by the attending (billing) provider.

4. Medical Records

Providers shall maintain comprehensive legible records on the premises. All services billed to the Medicaid Program shall be properly documented. Proper documentation consists of the following:

(a) Medical records in the office and clinic shall substantiate the services billed to the Medicaid Program by the dentist;

(b) The medical records shall be accurate and appropriate, and entered personally or countersigned (initialed) by the dentist;

(c) All records (including x-rays) shall be signed by the provider or an authorized agent and dated to reflect the date of service;

(d) The diagnosis shall substantiate the necessity of the procedure;

(e) Any treatment regimen shall be documented (diagnosis, treatment plan, treatment and follow-up) and must be medically indicated;

(f) Medical records (including x-rays) shall be maintained for a minimum of five (5) years and for any additional time as necessary in the event of an audit exception or other dispute;

(g) Medical records (including x-rays) and any other information regarding payments shall be maintained in an organized central file. These records shall be furnished to the Department upon request and made available for inspection and copying by Department personnel or its representative.

(h) The Department has the right to obtain original medical records or copies of original medical records upon request.

The provider's adherence to the application of policies in this manual shall be monitored through either postpayment review of claims by the Department, or computer audits or edits of claims. If computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect and thus the claims become subject to postpayment review by the Department.

5. Participation

(a) Participation in the Kentucky Medicaid Program as a clinic or professional service corporation requires a completed authorization form to be on file in the Department.

(b) Each participating dentist shall have a valid license to practice dentistry in the Commonwealth of Kentucky, (or the state in which they practice) and shall have the appropriate enrollment forms on file in the Department.

(c) The clinic or professional service corporation shall be assigned a provider number when all necessary documents have been completed and filed. This number shall be entered on all dental claims when billing the Medicaid Program for services provided to eligible recipients.

(d) If the clinic or professional service corporation provider number appears on the billing statement, payment shall be made directly to the clinic or corporation. If the clinic provider number is omitted from the billing statement, payment shall be made to the dentist whose name and provider number appear on the statement.

(e) The dentist's delegated signature (e.g., John Doe, D.M.D. by ab), or the dentist's actual signature shall appear on the billing form unless the Medicaid Program is notified that the responsibility for the signing of the billing forms has been delegated to the director, administrator, or other duly authorized personnel of the clinic or corporation. Facsimiles, stamped or computer generated signatures shall not be accepted.

(f) The name, address, and license number of the dentist who actually provided the service shall be entered in the appropriate spaces on the billing statement, except for supervising dentists in a teaching hospital as specified in Section III. D. 3.

E. Termination of Provider Participation

Termination of a provider participating in the Medicaid Program shall be in accordance with the Department for Medicaid Services' administrative regulation 907 KAR 1:671 which addresses the terms and conditions for provider termination and procedures for provider appeals.

PROGRAM COVERAGE

SECTION IV

SECTION IV - PROGRAM COVERAGE

IV. SERVICES COVERED

The dental services payable by the Kentucky Medicaid Program shall include procedures necessary for quality preventive and restorative dentistry to recipients. All services provided to recipients shall be completed prior to billing the Program for that service. This policy shall be monitored through postpayment review.

A. Out-of-Hospital Services: Payment for out-of-hospital services shall be limited to those procedures listed on the Department's Dental Manual.

The term "Out-of-Hospital" shall refer to all locations where dental services shall be provided, except hospital admittance. For example:

Clinic
Hospital Outpatient Department
Dentist's Office
Nursing Home
Patient's Home

B. Out-of-Office Services: The term "Out-of-Office Services" shall refer to locations where the dentist must travel away from his usual office to provide professional services. For example:

Nursing Home
Patient's Home
Hospital Outpatient Department

C. In-Hospital Services: The term "In-Hospital Service" shall refer to dental services provided to a patient admitted to a hospital overnight. Reimbursement for these procedures shall be on a fee for service basis, according to the Kentucky Medicaid Program maximum allowable fees. See Section V Reimbursement for further clarification of the payment methodology.

A general dentist may submit a claim for hospital inpatient service for the patient termed "medically high risk." Medically high risk shall be defined as a patient with one (1) of the following diagnoses:

Heart Disease
Respiratory Disease
Chronic Bleeder
Uncontrollable Patient, i.e, a person with mental or -emotional disorder
Other - e.g., automobile accident, high temperature, massive infection

All nonemergency hospital admissions shall be preauthorized by the Kentucky Medicaid Professional Review Organization (PRO).

To obtain prior authorization, a provider or his designated representative shall contact the PRO office for a preadmission review of proposed elective admissions. A **preauthorization** code shall be given to the provider or his designated representative by the PRO, indicating approval for the admission. A provider or his designated representative shall transmit that code to the hospital's admitting office at the time of the admission. This code shall allow the PRO coordinator to certify the admission. Kentucky hospitals shall not be reimbursed by the Medicaid Program for nonemergency admissions unless the admissions were preauthorized and certified by the PRO.

D. KenPAC Referrals

Dental and oral surgery services shall not require **KenPAC** referrals. Providers shall continue to bill as usual for any covered services provided to patients with a "green" Medical Assistance Identification (MAID) card.

E. General Policy Statements

The patient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the patient's name appears on the card and that the card is valid for the period of time in which the services are to be

rendered. If there is any doubt about the identity of the patient, you may request a second form of identification. A Provider can not be paid for services rendered to an ineligible person. Failure to validate the identity of a Medicaid recipient prior to a service being rendered may result in being out of compliance with KAR 1:671. Any claims paid by Medicaid Services on behalf of an ineligible person may be recouped from the Provider.

A comprehensive software auditing system has been designed to evaluate billing information and coding accuracy on claims submitted to Kentucky Medicaid. The logic of this oversight system shall supersede any audits,' edits, and policies previously implemented by the fiscal agent as directed by the Department for Medicaid Services. See Section V for further details.

ADA Statement

The ADA code description listed in the Dental Manual may vary from the description listed for the most current procedure code in the CDT-2 User Manual. The descriptor in the Kentucky Medicaid Manual is to be used on claims billed to the Medicaid Program.

F. Dental Benefits for General Dentists

The following list contains all procedures payable to general dentists by the Medicaid Program. If a service is not included, it shall not be payable by the Program. Dental providers shall maintain comprehensive medical records to substantiate services billed to the Kentucky Medicaid Program. Medical records shall include the patient's diagnosis and specific treatment provided. Reimbursement of funds shall be requested if medical records do not substantiate the services billed by listing specifically the treatment given and medical necessity of procedures performed. See Section III, Item #4 for further details.

SECTION IV - PROGRAM COVERAGE

DENTAL VISITS

Available to all ages

Procedure codes 00150, 09110 and 09420 are limited to one (1) per date of service, per recipient, per provider and shall not be billed conjunctively.

Procedure 00150 - Comprehensive Oral Evaluation (limited to one (1) per twelve (12) month period, per provider, per recipient)

NOTE: Procedure 00150 shall **not** be billed in conjunction with the following: 00140, 01510, 01515, 01520, 01525, 03310, 03320, 03330, 05750, 05751, 05820, 05821, 05913, 05914, 05919, 05931, 05932, 05934, 05952, 05953, 05954, 05955, 05988, 05999, 07880, 08210, 08220, 08660, 08670, 08999, 09110 and 09420.

Procedure 09110 - Palliative (emergency) treatment of oral pain; minor procedures only. Example: treatment of abscessed tooth, dry socket, pericoronitis, soft tissue ulcerations, or treatment of viral, fungal or bacterial infections. With the exception of radiographs, no other procedures may be billed in conjunction with 09110.

Procedure 09420 - Hospital Call (Not applicable for Nursing Home visits)

EMERGENCY TREATMENT

Emergency treatment shall refer to dental treatment necessary in an emergency situation, that is not covered by any other procedure. Dental emergencies shall be defined as an unexpected situation or sudden occurrence of a serious and urgent nature that demands immediate action. Documentation of patient's condition and actual treatment provided shall be submitted with the claim for procedure 00140. Only one (1) emergency may exist during any one (1) visit, even though treatment may involve more than one (1) procedure or tooth. **All claims billing 00140 shall be reviewed.**

Procedure 00140 - Emergency Call - Intermediate Level of Service, (trauma related injuries only) e.g., fractured teeth, soft tissue trauma, dental injuries sustained from a motor vehicle accident, avulsed teeth, alveolar bone fractures, lacerations, circumoral burns, and other unusual oral injuries. This procedure may be billed in conjunction with the following: 00220, 00230, 00270, 00272, 00274, 00330, 02330, 02331, 02332, 02335, 07110, 07120, 07130, 07250, 07530, 07910 and 09240. Other procedures shall not be billed in conjunction with procedure 00140.

NOTE: If billing procedure 00 140 the appropriate accident indicator block shall be marked to indicate patient was in an accident.

DIAGNOSTIC SERVICES

Available to all ages

Procedures 00220, 00230, 00270, 00272, and 00274 shall **not** be billed in the same twelve (12) month period as procedure 002 10.

Procedure 00270 - Bitewing - Single Film

Procedure 00272 - Bitewing - Two (2) Films

Procedure 00274 - Bitewing - Four (4) Films

Limit: A total of four (4) x-rays per recipient, per twelve (12) month period, per provider.

Procedure 00220 - Intraoral - Periapical Single, First Film

Procedure 00230 - Intraoral - Periapical Each Additional Film

Limit: A total of fourteen (14) x-rays per recipient, per twelve (12) month period, per provider.

NOTE: Tooth numbers shall be required if billing procedures 00220 and 00230.

Procedure 00210 - Intraoral - Complete series (including bitewings)

An Intraoral complete series consists of four (4) bitewings and fourteen (14) periapicals

Limit: One (1) per recipient, per twelve (12) month period, per provider.

Procedure 00330 - Panoramic Film - Maxilla and Mandible Film

Procedure 00340 - Cephalometric Film

Limit: One (1) per recipient, per twenty-four (24) month period, per provider.

NOTE: Cephalometric and Panoramic x-ray billings for Comprehensive Orthodontic patients shall be included in the 08660 (Orthodontic Consultation and Records) payment.

Procedure 07430 - Biopsy - Excision of benign tumor - lesion diameter up to 1.25 cm.

PREVENTIVE SERVICES

Procedure 01110 - Prophylaxis - Adult

NOTE: Adult shall be defined as age fourteen (14) and over.

Procedure 01201 - Prophylaxis - child (includes fluoride)

Limit: One (1) per twelve (12) month period, per recipient.
NOTE: Child shall be defined as age thirteen (13) and under.

Procedure 04341 (Periodontal Scaling and Root Planing) shall **not** be billed in conjunction with a dental prophylaxis.

Procedure 0 135 1 - Sealant - per tooth

Limit: Procedure 01351 shall be limited to recipients ages five (5) through twenty (20). Coverage involves one sealant per six (6) and twelve (12) year molars only (tooth numbers 2, 3, 14, 15, 18, 19, 30 and 3 1); the occlusal surface shall be non-carious. If necessary, sealants may be repeated on the above-mentioned teeth every four years with a limit of 3 per applicable tooth, per lifetime. Repair, replacement or reapplication of the sealant within the four years will be the responsibility of the provider at no additional expense to Medicaid or the recipient. No restorative procedures will be paid for the same tooth on the same date of service.

ORAL SURGERY

Available to all ages

EXTRACTIONS

Procedures 07110 and 07120 apply to simple, uncomplicated extractions. Procedure 07110 shall be used to bill the first tooth extracted on a given day; all additional teeth extracted on the same day shall be billed as procedure 07120. Surgical extractions or impactions were added to the scope of benefits for general dentists effective 1 1/01/87.

The removal of supernumerary teeth shall be billed listing the applicable extraction/impaction procedure code. Tooth numbers shall be entered in the "tooth number or letter" field of the claim form using number 33 forward.

SIMPLE EXTRACTIONS

Procedure 07 110 - Extraction, Single Tooth

Limit: One (1) per tooth, per recipient
One (1) initial extraction per date of service

Procedure 07120 - Extraction, Each Additional Tooth

Limit: One (1) per tooth, per recipient.

Procedure 07130 - Root Removal - Exposed Roots

NOTE: Root removal shall not be payable on same date of service to same tooth as the tooth's extraction.

IMPACTIONS

Procedure 07210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure.

NOTE: Simple use of an elevator shall not constitute a surgical extraction.

Procedure 07220 - Removal of impacted tooth - soft tissue
Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

Procedure 07230 - Removal of impacted tooth - partially bony
Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.

Procedure 07240 - Removal of impacted tooth - completely bony
Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.

Procedure 07241 - Removal of impacted tooth - completely bony, with unusual surgical complications
Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.

Procedure 07250 - Surgical removal of residual tooth roots (cutting procedure)

Includes cutting of gingiva and bone, removal of tooth structure, and closure.

NOTE: Root removal shall not be payable on the same date of service to same tooth as the tooth's extraction.

Procedure 07260 - Oroantral fistula closure (or antral root recovery)

Procedure 07280 - Surgical exposure of impacted or unerupted tooth for Orthodontic reasons,

NOTE: The exposure of an impacted or unerupted tooth shall be billed listing the tooth number in the "tooth number or letter" field of the claim form. A description indicating the level of complexity of the exposure (i.e., soft tissue, partially bony, or full bony) shall be included in the "remarks for unusual services" of the claim form.

Procedure 042 10 - Gingivectomy or gingivoplasty - per quadrant (minimum of three (3) teeth)

Limit: One (1) per quadrant, per twelve (12) months, per provider.

Procedure 04211 - Gingivectomy or gingivoplasty - per tooth (maximum of two teeth per quadrant)

Limit: One (1) per tooth, per twelve (12) months, per provider.

NOTE: These procedures shall be limited to recipients with gingival overgrowth due to congenital, hereditary or drug induced causes (e.g., Dilantin therapy). The patient's diagnosis shall be entered in the procedure description field of the claim form if billing procedures 042 10 and 042 11. Documentation including pocket depth measurements, a history of nonsurgical services and prognosis shall be maintained in the patient's permanent record. If billing for procedure 04210 the location of the quadrants being treated shall be indicated in the tooth nurnber field of the claim form by using the following abbreviations: LL, LR, UR, and UL. Tooth numbers shall be required for procedure 042 11.

Procedure 04341 - Periodontal scaling and root planing - per quadrant (minimum of three (3) teeth)

Dental providers shall maintain diagnostic records including periodontal charting of pre-operative pocket depths on patients receiving this treatment in case of postpayment review.

Limit: One (1) per quadrant, per twelve (12) months, per provider, If billing for subgingival scaling and root planing the location of quadrants being treated shall be indicated in the tooth number field of the claim form by using the following abbreviations: LL, LR, UR and UL.

NOTE: Exceptions shall be made for patients diagnosed with AIDS. AIDS patients shall be allowed one (1) scaling and root planing, per quadrant, per three (3) months, per provider. The patient's diagnosis shall be entered in the procedure description field of the claim form.

Periodontal scaling and root planing shall not be billed in conjunction with dental prophylaxis.

Procedure 073 10 - Alveoplasty (Alveoloplasty) in conjunction with simple extractions only per quadrant (minimum of three (3) teeth)

Procedure 07320 - Alveoplasty (Alveoloplasty) not in conjunction with extractions - per quadrant (minimum of three (3) teeth)

Limit: 073 10 and 07320 shall be limited to one (1) per quadrant, per lifetime, per recipient. If billing for alveoplasties indicate the location of the quadrants in the tooth number field of the claim form by using the following abbreviations: LL, LR, UR, and UL.

Procedure 075 10 - Incision and drainage of abscess - Intraoral soft tissue

Procedure 07520 - Incision and drainage of abscess - Extraoral soft tissue

Procedure 07530 - Removal of foreign body, skin or subcutaneous areolar tissue

NOTE: Shall not pertain to removal of stitches (sutures) or teeth.

Procedure 07910 - Suture of recent small wounds up to five (5) cm.

NOTE: Procedure 079 10 shall not be billed in conjunction with any other surgical procedure. It shall not pertain to repair of surgically induced wounds.

Procedure 07960 - Frenulectomy (Frenotomy or Frenectomy-separate procedure)

Limit: This procedure code shall be limited to one (1) per date of service.

Procedure 09240 - Intravenous Sedation

Limit: Limited to recipients under age twenty-one (21).

NOTE: This procedure code shall not be used for billing local anesthesia or Nitrous Oxide.

ENDODONTIC SERVICES

Limited to recipients under age twenty-one (2 1)

Procedure 03 110 - Pulp Cap - Direct

NOTE: Direct pulp cap shall be defined as the application of a pulp capping material such as calcium hydroxide placed directly on or in contact with the vital pulp tissue. Placement of the material

over an area in close proximity of the pulp but not actually in contact with the pulp chamber shall not constitute a direct pulp cap.

Procedure 03220 - Vital Pulpotomy (Excludes Final Restoration)

NOTE: Procedure 03220 shall not be billed in conjunction with procedures 033 10, 03320, and 03330 on the same date of service.

Procedure 033 10 - Root Canal Therapy, anterior (Excludes Final Restoration)

Procedure 03320 - Root Canal Therapy, bicuspid (Excludes Final Restoration)

Procedure 03330 - Root Canal Therapy, molar (Excludes Final Restoration)

NOTE: The Sargenti method of root canal treatment shall not be covered under the present root canal procedure codes. This shall be monitored through postpayment review. If billing for root canal therapy, the procedure constitutes treatment of the entire tooth. It shall not be appropriate to perform a root canal on only one (1) root of a molar and bill the Kentucky Medicaid Program for root canal therapy on a molar since that code represents treatment to the entire tooth. Providers shall not bill for root canal therapy until after it has been completed. An x-ray shall be taken before and after completion of root canal therapy to demonstrate that the services were medically necessary and appropriately performed. These x-rays shall be maintained in the patient's record, but shall not be required for claim submission. This shall be monitored through postpayment review.

Procedure 03410 - Apicoectomy anterior

Procedure 03421 - Apicoectomy - bicuspid (first root)

Procedure 03425 - Apicoectomy - molar (first root)

Procedure 03426 - Apicoectomy (per tooth) - each additional root

NOTE: Procedures 03410, 03421, 03425, and 03426 shall be available to all ages.

OPERATIVE SERVICES

Available to all ages

AMALGAM - PRIMARY

Procedure 02 110 - Amalgam - One (1) Surface
Procedure 02120 - Amalgam - Two (2) Surfaces

Procedure 02 130 - Amalgam - Three (3) Surfaces

Procedure 02 13 1 - Amalgam - Four (4) or more Surfaces

AMALGAM - PERMANENT

Procedure 02140 - Amalgam - One (1) Surface

Procedure 02150 - Amalgam - Two (2) Surfaces

Procedure 02 160 - Amalgam - Three (3) Surfaces

Procedure 02 16 1 - Amalgam - Four (4) or More Surfaces

COMPOSITE RESIN

Procedure 02330 - Resin - One (1) Surface, anterior

Procedure 0233 1 - Resin - Two (2) Surfaces, anterior

Procedure 02332 - Resin - Three (3) Surfaces, anterior

Procedure 02335 - Acrylic or Plastic or Composite Resin - Four (4) or More Surfaces or Involving Incisal Angle (Anterior)

NOTE: This procedure code shall not be billed in conjunction with any other operative service code or the procedure code for crowns performed on the same tooth on the same date of service. The use of cosmetic bonding or veneering shall not be allowed for this procedure code. Policy shall be monitored through postpayment review.

Procedure 02380 - Resin - One (1) Surface, posterior - primary

Procedure 0238 1 - Resin - Two (2) Surfaces, posterior - primary

Procedure 02382 - Resin - Three (3) or More Surfaces, posterior - primary

Procedure 02385 - Resin - One (1) Surface, posterior - permanent

Procedure 02386 - Resin - Two (2) Surfaces, posterior - permanent

Procedure 02387 - Resin - Three (3) or More Surfaces, posterior - permanent

NOTE: The Kentucky Medicaid Program shall recognize five (5) surfaces of a tooth (buccal or facial, mesial, distal, lingual, occlusal or incisal). If billing for amalgam or resin fillings enter the appropriate surface indicator in the "surface" field (e.g., M, 0, D, B, L, I or F). Anterior teeth shall be defined as tooth numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, 0, P, Q, and R.

CROWN

Limited to recipients under age twenty-one (2 **1)**

Procedure 02930 - Prefabricated Stainless Steel Crown - Primary Tooth

Procedure 0293 1 - Prefabricated Stainless Steel Crown - Permanent Tooth

Procedure 02932 - Prefabricated Resin Crown

NOTE: If a provider chooses to provide crowns other than stainless steel for anterior teeth, the usual and customary charge for a stainless crown shall be billed. Reimbursement for the tooth's restoration shall be included in the payment for the crown. This policy shall be reviewed by both system audits and postpayment review.

Procedure 0295 1 - Pin Retention - per tooth, in addition to restoration

Limit: Shall be limited to permanent molars; used in conjunction with procedures 02 160, 02 161, or 0293 1 and 02932. Lifetime maximum of two (2) per permanent molar. Procedure 0295 1 shall be limited to one (1) per tooth, per date of service and is available to recipients of all ages.

PROSTHETIC SERVICES

Limited to recipients under age twenty-one (2 1)

TRANSITIONAL APPLIANCE

An acrylic or plastic appliance, so named because of its application during the period of transition from the primary to the permanent dentition; space maintenance or space management, and interceptive or preventive orthodontics.

Procedure 05820 - Transitional appliance, includes one (1) tooth on appliance, upper appliance

Limit: One (1) per twelve (12) month period, per recipient.

Procedure 0582 1 - Transitional appliance, includes one (1) tooth on appliance, lower appliance

Limit: One (1) per twelve (12) month period, per recipient.

SECTION IV - PROGRAM COVERAGE

SURGICAL OBTURATORS

Procedure 0593 1 - Obturator (Temporary)

Procedure 05932 - Obturator (Permanent)

NOTE: The additional prosthodontic procedures listed below shall be covered through the Kentucky Medicaid Dental Program for prosthodontists only.

Procedure 05913 - Nasal Prosthesis

Procedure 059 14 - Auricular Prosthesis
Procedure 05919 - Facial Prosthesis

Procedure 05934 - Mandibular Resection Prosthesis

Procedure 05952 - Speech Aid - Pediatric

Procedure 05953 - Speech Aid - Adult

Procedure 05954 - Palatal Augmentation Prosthesis

Procedure 05955 - Palatal Lift Prosthesis
Procedure 05988 - Oral Surgical Splint

Procedure.05999 - Unlisted Maxillofacial Prosthetic Procedure (By Report)

Procedure **07880 - Temporomandibular Splint Therapy**

Temporomandibular Joint (TMJ) Splint Therapy shall be available to all Kentucky Medicaid Program recipients under age twenty-one (2 1) who meet the prior authorization criteria. Coverage shall be specifically for recipients requiring treatment if medically necessary to correct TMJ dysfunction.

Occlusal Orthotic Appliance (Temporomandibular Splint Therapy) e.g., flat plane splint or anterior repositioning splint

Limit: Limited to recipients under age twenty-one (21); one (1) per lifetime, shall require prior authorization.

This service shall be reviewed by dental consultants to verify medical necessity.

In order to receive prior authorization for TMJ splint therapy, the provider shall complete the appropriate prior authorization forms. These forms shall be sent to the fiscal agent.

Upon receipt of the prior authorization request, the information shall be reviewed by a dental consultant who shall determine whether the service can be authorized. Once the determination has been made, a letter indicating approval or disapproval shall be returned to the provider.

DENTURE REPAIRS

Limited to recipients under age twenty-one (21)

The repair of clasp on removable partial dentures, and relining of removable partial dentures, shall not be covered benefits. This shall be monitored through postpayment review.

Procedure 05610 - Repair resin denture base

Limit: Three (3) per twelve (12) month period, per patient.

Procedure 05620 - Repair cast framework

Limit: Three (3) per twelve (12) month period, per patient.

Procedure 05640 - Replace broken teeth - per tooth

Procedure 05520 - Replace missing or broken teeth - Complete Dentures - No other repairs

Procedure 05750 - Reline complete maxillary denture (laboratory)

Procedure 0575 1 - Reline complete mandibular denture (laboratory)

Limit: One (1) per twelve (12) month period, per procedure code (denture), per recipient.

ORTHODONTIC SERVICES

Limited to recipients under age twenty-one (21)

Procedures 01510, 01515, 01520, 01525, 08210, 08220 refer to an appliance necessary for the minor tooth movement or guidance of one (1) or a few teeth. Providers shall maintain documentation in the patient's medical record substantiating the medical necessity of the procedure, including the necessary evaluation to formulate a diagnosis and plan of treatment including follow-up visits. The simple reference of "spaces" or "crowding" shall be unacceptable. Payment under these codes applies to the fabrication insertion and all follow-up visits and adjustments. Billing for these procedure codes shall be submitted only after placement of the appliances.

With the exception of procedure 015 10 and 0 1520 which require a tooth number, if billing the above-mentioned codes the appropriate arch location shall be indicated by using the abbreviations UA (upper arch) or LA (lower arch) in the tooth number field of the claim form.

Limit: To any combination of the following procedures per twelve (12) month period totaling two (2), per recipient to be billed within the guidelines of the claim auditing system. Procedures 01510, 01515, 01520, 01525, 08210, 08220 shall not be billed in conjunction with Comprehensive Orthodontics.

NOTE: The Department for Medicaid Services does not permit the use of or reimburse providers for reconditioned or refurbished orthodontic brackets or appliances.

FIXED SPACE MAINTAINER

Definition: An appliance requiring cemented orthodontic bands with varying attachments such that patient removal or adjustment is difficult.

Procedure 0 15 10 - Space maintainer, fixed unilateral type
Examples: a. Band and Loop
b. Cantilever type

Procedure 015 15 - Space maintainer, fixed bilateral type
Examples: a. Soldered or adjustable lingual arch
b. Soldered or adjustable transpalatal arch
c. Cantilever type

REMOVABLE SPACE MAINTAINER

Definition: A space maintenance appliance which is readily removed by the dentist or the patient. The appliance may or may not have bands or stainless steel crowns.

Procedure 0 1520 - Space maintainer, removable unilateral type

Procedure 01525 - Space maintainer, removable bilateral type

Example: Acrylic base appliance with or without clasps or teeth

NOTE: 01510, 01515, 01520 and 01525 shall be used for the maintenance of existing inter-tooth space.

REMOVABLE APPLIANCE FOR MINOR TOOTH GUIDANCE

Definition: An appliance, used for the positioning of one (1) or a few teeth, that is readily removed by the dentist or patient.

Procedure 082 10 - Removable Appliance Therapy

NOTE: This appliance is not to be used to control harmful habits (See ADA statement on Page 4.3).

Example:
a. Hawley type with a variety of activating attachments
b. Lip bumper with a variety of activating attachments
c. Headgear with two (2) molar bands and a facebow

FIXED OR CEMENTED APPLIANCE FOR MINOR TOOTH GUIDANCE

Definition: An appliance requiring cemented orthodontic bands, with varying attachments for the positioning of one (1) or a few teeth, such that patient removal or adjustment is difficult.

Procedure 08220 - Fixed or cemented appliance therapy

NOTE: This appliance is not to be used to control harmful habits (See ADA statement on Page 4.3).

Examples:
a. Adjustable lingual arch
b. Adjustable transpalatal arch
c. Crossbite correction (two (2) bands and crossbite elastic)
d. Segmented arch appliance (usually used for molar rotation and limited to one (1) quadrant)

COMPREHENSIVE ORTHODONTIC SERVICES - PRIOR AUTHORIZATION

Comprehensive orthodontics shall be available to all Kentucky Medicaid Program recipients under age twenty-one (21) who meet the prior authorization criteria. Coverage shall be specifically for recipients requiring orthodontic treatment if medically necessary to correct disabling malocclusions. All services through this

program shall be reviewed by orthodontic consultants to verify medical necessity. Since a case shall be disabling to be accepted for care under the Program, recipients whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually functional in spite of esthetic consideration. An antero-posterior problem shall be one (1) full cusp in magnitude in order to be considered. Services provided for cosmetic purposes shall not be considered for prior authorization approval.

Comprehensive orthodontics shall be available only for transitional (mixed) or full permanent dentition. Exception to this policy shall only be granted in cases of cleft palate or severe facial anomalies where early intervention is in the best interest of the recipient.

The recipient shall also be a good candidate for comprehensive orthodontic treatment in that he exhibited a history of good oral hygiene. The recipient shall also be under the care of a general dentist for routine care and all general dentistry (e.g., prophylaxis, fillings, etc.) shall be completed prior to submission of the prior authorization request.

Providers shall be required to sign a contract with the initial prior authorization for treatment. Failure to abide by the regulations of the Medicaid Program shall be considered a breach of contract and may result in a request for reimbursement of funds, expulsion from the orthodontic program, or both.

In order to receive prior authorization for comprehensive orthodontic services, the provider shall complete the appropriate prior authorization forms. These forms along with the diagnosis, cephalometric x-rays with tracing, panoramic x-ray, intraoral and extraoral facial pictures (both frontal and profile) and properly occluded and trimmed dental models shall be sent to the fiscal agent.

If the models or x-rays are unusable, they shall be rejected and new records shall be resubmitted for a prior authorization determination to be made.

Upon receipt of the prior authorization request, the information shall be reviewed by an orthodontic consultant who shall determine whether the service can be authorized. Once the determination has been made, a letter indicating approval or disapproval shall be returned to the provider along with the cephalometric x-ray with tracing, panoramic x-ray, intraoral and extraoral facial pictures, models, etc.

SECTION IV - PROGRAM COVERAGE

The Kentucky Medicaid Program shall reserve the right to request that a patient obtain a second opinion regarding the proposed diagnosis and treatment plan.

Final records accompanied by original records consisting of a panoramic x-ray, a cephalometric x-ray with tracing, properly occluded and trimmed models, and intraoral and extraoral facial pictures (both frontal and profile) shall be submitted to the fiscal agent upon completion of the treatment plan. Failure to submit finished records within three (3) months after completion of treatment shall result in a request for recoupment of payments made to the provider. Additional measures may be made to remove the provider from the Orthodontic Program.

Providers shall be required to retain copies of the patient history and prior authorization forms, cephalometric x-ray with tracing, panoramic x-ray, pictures and models for a minimum of five (5) years as required for all other medical records associated with Medicaid billing. If orthodontic treatment is interrupted for an extended period of time, transferred, or ceased for any reason, payment to the provider shall be determined on a prorated basis.

The following protocol shall be observed in the event of treatment termination or patient transfer:

1. The appropriate referral form shall be submitted to the fiscal agent by the original provider accompanied by a letter outlining treatment status 1) dates seen, 2) treatment given, 3) progress made with prorated fee. Prorated fees shall be evaluated by the orthodontic consultants.

2. If the patient is Medicaid eligible and under the age of twenty-one (21) at the time of transfer, the receiving provider may submit an authorization request for the remainder of treatment. Resubmissions require all appropriate prior authorization forms, and shall be accompanied by original records (x-rays, models and photographs) and recent progress records if the original records are over a year old. If the second provider concurs completely with the initial treatment plan he shall indicate this by a signed statement submitted to the fiscal agent. Reimbursement shall be made on a prorated basis.

3. The initial provider shall forward a copy of the referral form and the original records to the receiving provider, if the recipient is Medicaid

eligible and under the age of twenty-one (21) at the time of transfer and the patient is transferring to another Medicaid provider.

Coverage for orthodontic treatment shall be approved in some instances for recipients whose treatment began prior to their Medicaid eligibility. Submission of current records (x-rays, models and photographs) accompanied by original records shall be submitted to the fiscal agent for payment consideration. The prior authorization forms shall also be necessary for this submission. The provider may submit the original records if the records are less than one (1) year old. Reimbursement for these cases shall be made on a prorated basis. To qualify for coverage, the patient's pretreatment status shall meet the program criteria as a disabling malocclusion.

Procedure 08660 - Consultation - Orthodontic Exam and Treatment Plan (Includes diagnosis, treatment plan, cephalometric x-ray with tracing, panoramic x-ray, intraoral and extraoral facial pictures (both frontal and profile), prior authorization forms, impressions and models)

NOTE: In order to receive reimbursement for this procedure, the provider shall submit the above services (i.e., x-rays with tracing, models, pictures, etc.) to the fiscal agent as verification that the work was actually performed. All records and models shall be no more than six (6) months old at the time of submission and all models shall be properly occluded, trimmed and labeled with name of provider and recipient. The cephalometric x-ray shall include a tracing. Reimbursement for this procedure shall be 100 percent of the allowable fee if the comprehensive services shall be approved. Reimbursement for cases not approved, or cases where the provider is referring the recipient to a specialist or declines to treat the patient shall be one-half (1/2) of the allowable fee for this procedure (08660). The recipient shall be under twenty-one (2 1) years of age and Medicaid eligible on the record date:

SECTION IV - PROGRAM COVERAGE

Procedure Code 08670 - Fixed Appliance Therapy

NOTE: The Department for Medicaid Services does not permit the use of or reimburse providers for reconditioned or refurbished orthodontic brackets or appliances.

Reimbursement for 08670 shall equal two-thirds (2/3) of the total reimbursement for fixed appliance therapy and include all services associated with Comprehensive Orthodontics (i.e., bar placement, spacers, banding, visits and all retainers). Procedures 015 10, 01515, 01520, 01525, 08210 and 08220 shall not be billed in conjunction with comprehensive orthodontics. The recipient shall be under twenty-one (21) years of age and Medicaid eligible on the date of banding.

A potential problem may occur if a recipient loses Medicaid eligibility after orthodontic treatment has been initiated, but prior to their surgery date. If the recipient is not eligible on the date of the surgery, Medicaid shall not pay for the service provided. It is suggested that the provider implement a waiver, prior to the start of orthodontic treatment, to inform the patient or responsible party that Medicaid shall not guarantee coverage for surgical completion of the treatment unless the patient is eligible on the, surgery date.

For surgical cases, the provider shall take the recipient's eligibility status into consideration in formulating the initial treatment plan. In some instances, an acceptable outcome may be achieved without a surgical approach. Dental providers submitting prior authorization requests for comprehensive orthodontic treatment for recipients who will require orthognathic surgery as part of that treatment must include the pre-treatment work-up notes from the oral surgeon. Approval for payment of 08670 does not imply coverage for the surgical component required in some instances.

Although retainers shall not be prepared and placed for several months after receiving payment for orthodontic treatment the reimbursement for retainers shall be included in the fee.

Procedure Code 08999

The remaining third (1/3) of the reimbursement for fixed appliance therapy may be billed following the banding date of service after six (6) monthly visits are completed. The banding date shall be used for the date of service when billing procedure 08999. A patient progress report and prior authorization form shall be submitted to the fiscal agent for final payment authorization. This progress report listing a brief description of monthly visits shall be reviewed for continuity of care and present status of patient's condition.

If the progress report indicates that all program requirements have been met (i.e., as per the Medicaid Program Orthodontic Services Agreement) the **final** third (1/3) of payment shall be authorized at that time. Providers shall always ensure that the recipient is eligible and under age twenty-one (2 1) years of age for coverage on the day the comprehensive orthodontic treatment begins (records or consultation date) and again on the banding date or date the appliances shall be placed.

NOTE: Submissions for prior authorization for the final third (1/3) of payment shall be made no less than six (6) months and no more than twelve (12) months after the banding date of service. Monthly visits shall occur no less than three (3) weeks in frequency.

G. Dental Benefits for Oral Surgeons (Available to All Ages)

The following list contains all procedures payable to oral surgeons under the Kentucky Medicaid Dental Services Program. All other oral surgical procedures, including x-rays, shall be billed under the Physician Services Program, shall use the appropriate physician billing form and include the physician provider number. Please refer to your Physician Manual for program coverage.

EXTRACTIONS

Procedures 07110 and 07120 shall apply to simple, uncomplicated extractions. Procedure 07110 shall be used to bill the first tooth extracted on a given day; all additional teeth extracted on the same day shall be billed as procedure 07 120.

The removal of supernumerary teeth shall be billed listing the applicable extraction/impaction procedure code. Tooth numbers shall be entered in field "tooth number or letter" of the claim form using number 33 forward.

SIMPLE EXTRACTIONS

Procedure 07 110 - Extraction, Single Tooth

Procedure 07 120 - Extraction, Each Additional Tooth

Procedure 07130 - Root Removal - Exposed Root

Limit: One (1) extraction per tooth, per recipient

IMPACTIONS

Procedure 07210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone or section of tooth. Includes cutting of gingiva' and bone, removal of tooth structure, and closure.

NOTE: Simple use of an elevator shall not constitute a surgical extraction.

Procedure 07220 - Removal of impacted tooth - soft tissue
Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

Procedure 07230 - Removal of impacted tooth - partially bony
Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.

Procedure 07240 - Removal of impacted tooth - completely bony
Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.

Procedure 07241 - Removal of impacted tooth - completely bony, with unusual surgical complications.
Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.

Procedure 07250 - Surgical removal of residual tooth roots (cutting procedure).
Includes cutting of gingiva and bone, removal of tooth structure, and closure.

NOTE: Root removal shall not be payable on the same date of service to same tooth as the tooth's extraction.

Procedure 07260 - Oroantral fistula closure (or antral root recovery)

Procedure 07280 - Surgical exposure of impacted or unerupted tooth for Orthodontic reasons

NOTE: The exposure of an impacted or unerupted tooth shall be billed listing the tooth number in the "tooth , number or letter", of the claim form. A description indicating the level of complexity of the exposure (i.e., soft tissue, partially bony, or full bony) shall be included in field 38 of the claim form.

SECTION IV - PROGRAM COVERAGE

ANESTHESIA BILLINGS

Claims for intravenous sedation or general anesthesia shall be submitted through the physician's portion of the program. Please refer to the Physician Manual, relating to Oral Surgery Services for reporting these specific services.

REIMBURSEMENT

SECTION V

SECTION V - REIMBURSEMENT

V. REIMBURSEMENT

The Department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients as outlined in the dental regulation 907 KAR 1:626.

A. Out-of-Hospital Reimbursement -- (Applicable to Outpatient Services Listed in the Dental Manual)

B. Deductibles and Coinsurance Under Title XVIII, "Medicare"

1. Deductible: The Kentucky Medicaid Program shall make payment in accordance with its usual, customary, and prevailing fee system, for those applicable dental services which fall within the patient's deductible liability. These services shall be listed in the Program's Dental Manual.

2. Coinsurance: The Kentucky Medicaid Program shall make payment of coinsurance amounts at the rate of twenty (20) percent of its usual, customary, prevailing fee system for applicable services provided to its recipients under Title XVIII - Part B of Medicare (after satisfaction of the deductible) that shall be services covered by the Program. Policies and procedures governing the dental services phase of the Program shall pertain to payment of Medicare deductible and coinsurance amounts.

C. In-Hospital Benefit Reimbursement (General Dentists)

"In-Hospital" service shall be reimbursable per admission, on a fee for service basis, according to the Kentucky Medicaid Program maximum allowable fees.

SECTION V - REIMBURSEMENT

D. Oral Surgery Reimbursement (Applicable to Oral Surgeons)

The Department shall reimburse participating oral surgeons for covered services provided to eligible Medicaid recipients as outlined in the dental regulation 907 KAR 1:626.

E. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the Kentucky Medicaid Program, whether due to erroneous billing or payment system faults, shall be refunded to the Program. Refund checks shall be made payable to "Kentucky State Treasurer" and sent immediately to the fiscal agent.

Effective July 1, 1994, the Kentucky Medicaid Program implemented a comprehensive, computerized auditing system for provider claims submitted for payment. The auditing system was designed to evaluate billing information and coding accuracy on claims submitted for payment. Based on standardized criteria and protocols accepted by the dental community and including authoritative dental coding systems of the American Dental Association Current Dental Terminology (CDT), HCFA Common Procedural Coding System (HCPCS), Universal coding and Nomenclature (WAN), American Academy of Periodontology (AAP), and the Health Insurance Association of America (HIAA), this automated system of checking claims shall be utilized to detect miscoding and irregularities, such as unbundling which involves billing two (2) or more individual dental codes that may be combined under a single code and charge, mutually exclusive procedures, incidental or integral procedures, etc. The logic of this oversight system shall supersede any Kentucky Medicaid audits or edits previously implemented. As complex developments in dental technology are introduced and require more specific coding, this automated, claim checking system shall be updated to assist in processing and paying claims for Medicaid Services in a way more closely aligned and consistent with standardized dental practices and International Classification of Disease (ICD) criteria.

SECTION V - REIMBURSEMENT

F. Identification of Third Party Resources

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider shall inquire if the recipient meets any of the following conditions: If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer; if the recipient is a minor, ask about the insurance the MOTHER, FATHER, or GUARDIAN may carry on the recipient; in cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder; for people over sixty-five (65) or disabled, seek a Medicare HIC number; ask if the recipient has health insurance, MEDICARE SUPPLEMENT policy, CANCER, ACCIDENT, or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc., EXAMINE THE RECIPIENT'S MONTHLY ELIGIBILITY CARD FOR AN INSURANCE INDICATOR AND IF AN INDICATOR IS PRESENT, QUESTION THE RECIPIENT FURTHER REGARDING OTHER INSURANCE.

G. Reimbursement in Relation to Third Party Coverage

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program all participating providers shall submit billings for medical services to a third party resource if the provider has prior knowledge that the third party may be liable for payment for the services.

If the recipient has third party resources that cover the medical service, then the provider shall obtain payment or rejection from the third party before a claim against the Medicaid Program can be filed. If payment is received, the provider shall indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy number(s) of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice shall be attached to the Medicaid claim.

In those situations where the provider is unable to obtain the assignment and **cannot** bill the third party, the provider shall bill the Medicaid Program in the usual manner. The insurance or third party information shall be forwarded on the TPL lead to the fiscal agent.

This procedure shall be necessary so that the Medicaid Program through its fiscal agent may bill the insurance company for any portion which should have been paid by the liable third party.

H. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for the Medicaid Program payment shall be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party shall be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the Medicaid Program payment shall be zero. Recipients shall not be billed for any difference between the billed amount and Medicaid payment amount, Providers shall accept Medicaid payment as payment in full.
Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

Following is a list of the insurance codes on the MAID card:
A - Part A, Medicare only
B - Part B, Medicare only
C - Both Parts A and B Medicare
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private Medical Insurance
G - Champus
H - Health Maintenance Organization
J- Unknown
K - Other
L - Absent Parent's Insurance
M - None
N - United Mine Workers
P - Black Lung
R - Medicare Part A, Medicare Premium Paid
S - Both Parts A & B, Medicare Premium Paid

For additional information contact the Department's fiscal agent.

SECTION V - REIMBURSEMENT

I. Comprehensive Orthodontics

Reimbursement for the initial orthodontic consultation examination and records shall be 100 percent of the allowable for all claims receiving preauthorization approval. Reimbursement for those cases not receiving approval or for those cases where the services shall be either not necessary at this time or the provider is referring the recipient to a specialist shall be one-half (1/2) of the allowable rate for orthodontic consultation and records (08660).

Reimbursement for the remaining comprehensive services shall be two-thirds (2/3) of the allowable for that procedure code. The remaining third (1/3) of the total reimbursement may be billed six (6) months after the banding date of service.

If orthodontic treatment is interrupted for an extended period of time, transferred or ceased for any reason, payment to the provider shall be determined on a prorated basis.